

Exhibit 20

to 7521809 (FSTD800), received at 02/06/2007 11:56:00 from (12129033588).

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CENTRAL ACCESSION OFFICE

11380 P.001 / 003



CLAIMANT'S SUPPLEMENTAL STATEMENT

The Benefits Center
PO Box 100158
Columbia, SC 29202-3158

Phone: 1-800-858-6843 Fax: 1-800-447-2498



02873000827865404

ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient: Gallo, Francesco
Employer Name/Address: *retired 5/30/06*
Home Telephone Number: (272) 751-7350
Date of Birth: July 26, 1941
Social Security Number: 104-42-3023
Employer Telephone Number: *N/A*

Instructions: The following sections must be completed and signed by the attending physician. The purpose of this report is to assist in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or test results. In all situations, you must complete the signature block at the bottom of this form.

Normal Pregnancy

a) Expected Delivery Date: *5/30/06* b) Actual Delivery Date: *5/30/06* c) Delivery Type: ☒ Vaginal ☐ C-Section
Date First Unable to Work: *5/30/06* d) Hospitalized: *Yes*

All Other Conditions

Patient Information

a) Height: *6'7"* Weight: *169 lb* b) Date of first visit regarding current condition: *5/30/06*
c) Date patient ceased work because of condition: *5/30/06* d) Did you advise patient to cease work? ☒ Yes ☐ No If yes, when?
e) Has the patient been treated for the same/similar condition in the past? ☐ Yes ☒ No If yes, when?
If yes, please describe: *N/A*

f) Is the patient's condition due to injury or sickness involving the patient's employment? ☒ Yes ☐ No ☐ Unknown

Primary Diagnosis

a) What is the primary diagnosis preventing your patient from working?
Controlateral Degeneration (333.0)

Please include Primary ICD-9 and/or DSM-IV Mental Disorder and Codes
same as above

b) Date of last examination: *11/27/06*

c) Describe Subjective Symptoms: *intermittent controlling arms R & L*

d) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)
Paros, ataxia, falls, long balance

Other Conditions (Please attach additional information as necessary)
Parkinsonian features on exam, weakness R & L

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

a) Secondary ICD-9s

b) Secondary ICD-10s

c) Describe Subjective Symptoms

d) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

e) Describe Subjective Symptoms

f) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

g) Describe Subjective Symptoms

h) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

i) Describe Subjective Symptoms

j) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

k) Describe Subjective Symptoms

l) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

m) Describe Subjective Symptoms

n) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

o) Describe Subjective Symptoms

p) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

q) Describe Subjective Symptoms

r) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

s) Describe Subjective Symptoms

t) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

u) Describe Subjective Symptoms

v) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

w) Describe Subjective Symptoms

x) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

y) Describe Subjective Symptoms

z) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

aa) Describe Subjective Symptoms

ab) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

ac) Describe Subjective Symptoms

ad) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

ae) Describe Subjective Symptoms

af) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

ag) Describe Subjective Symptoms

ah) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

ai) Describe Subjective Symptoms

aj) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

ak) Describe Subjective Symptoms

al) Describe Objective Findings (MRI, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF, etc.)

Fax to 7521809 (FISTDB00) received at 02/06/2007 11:56:00 from (12129033588).

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JAN:10.2007 12:16 2127747806

CENTRAL ACCREDITATION OFFICE

#1360 P.002 / 003



02878000627863405

Claimant Name: Gallo, Francesco

Social Security Number: 109-42-3023

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	To
Michael Zullo	Cardiology					
Dr. Meyers	Neurology					
Dr. Steen	Psychiatry					

Physical Capabilities

a) Patient's ability to: (Please Check Number of Hours Per Workday and How Often)

Number of Hours	How Often	Continuously	Intermittently
Sit 0-1	<input checked="" type="checkbox"/> 0-1	<input type="checkbox"/> 0-1	<input type="checkbox"/> 0-1
Stand 1-2	<input type="checkbox"/> 1-2	<input type="checkbox"/> 1-2	<input type="checkbox"/> 1-2
Walk 3-4	<input type="checkbox"/> 3-4	<input type="checkbox"/> 3-4	<input type="checkbox"/> 3-4

b) Patient's ability to: (Please Check)

Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c) Patient's ability to lift/carry: (Please Check)

Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d) Patient's ability to perform: (Please Check)

Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Psychological Functioning

Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation.

Depressed/Anxious because of permanent disability

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work? ☒ Yes ☐ No Expected Return to Work Date: *permanent disability*

c) Restrictions (each restriction should not be):

totally restricted

d) LIMITATIONS (activities patient cannot do)

totally restricted

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of this claim form.

Print or Type Name

John J. Carabona

Degree

MD

Medical Specialty

Neurology

Street Address

520 E 70 St

City

NYC 100 21

State

ZIP Code

Telephone Number

(212) 746-2309

Signature of Physician

[Signature]

Date

SSN or Employer's ID Number

131-62-3978

Are you, the physician, related to this patient? ☐ Yes ☒ No If yes, what is the relationship?

1006-01-01-0000